CASE MANAGEMENT STANDARDS FOR COMMUNITY CASE MANAGEMENT SERVICES FOR PEOPLE WITH MENTAL RETARDATION/AUTISM

April 2003

Mission Statement

Mental Retardation Services will provide leadership and be an active partner in Maine's comprehensive system of support to individuals with mental retardation and autism. At the foundation of this system is the belief that all individuals, through self-determination, can achieve a quality of life consistent with the community in which they live. Supports will be flexible and designed in a manner that recognizes people's changing needs throughout their lifetimes.

I.INTRODUCTION

Role of Community Case Management:

Case management services for people with mental retardation and autism have been provided through the state system for over twenty-five years. It is an integral part of a service delivery system that includes housing, employment, day habilitation, adult protective, guardianship, representative payee, quality assurance and other functions. With the growth of the mental retardation system it is evident that this service needs to expand beyond the state delivery system.

The expansion of this service is for people eligible for mental retardation services 34-b living at home with their families who are not receiving waiver services and is not under public guardianship.

The role of the community case manager involves working with the participant and others that are identified by the participant such as family members in developing an individualized support plan, and assisting the person to implement that plan. The community case managers primary customer is the person with disabilities and their families. Community case managers will work closely with the participant to assure his or her ongoing satisfaction with the process and outcomes of the supports, services and available resources. It is very important that the community case manager recognize that the person is now an adult and that the role of the family in supporting this person changes even with guardianship possibly in place. The primary role of the community case manager is to assists in identifying and implementing support strategies that reflect the participant's personal vision for a desired life

There are also several roles and responsibilities that the community case manager needs to balance while providing this primarily role:

- Relationship with family- it is clear that for the population identified for case management services the role of family in their lives is very important. The case manager needs to take the lead whenever appropriate from the person with disabilities regarding the involvement of family members, however it is the intention of this service to include family in the circle of support whenever it is possible and desired by the person.
- Relationship with Mental Retardation Services – the community case manager should see themselves as an extension of the over-all case management system for mental retardation. A great deal of support will be available through access to information systems, resources, training and education, and quality assurance to assure that the community case worker

has the same resources and access as their counterparts in the state system. With that come responsibilities in regards to professional conduct and working partnership and relationship between the state and private case management system. It is clear this is in the best interest of the people receiving this service.

- Relationship with other providers- It is imperative that the community case manager strives to maintain quality relationships with community supports and community providers. This will facilitate access to services for the people they represent. If conflicts or dissatisfaction occurs for the consumer with other community supports or providers it is the role of the community case manager to assist the consumer and family to work through those problems.
- Relationship with community- you will see in the description of this service a very heavy emphasis on community. There is a strong belief that people providing case management who know the local community and the possibilities that exist for people is vital. Thus, maintaining a positive professional relationship with member of the local community and working to access opportunities for people with disabilities is an essential part of this work.

These Case Management Standards have been developed by the Department of Behavioral and Developmental Services to provide guidance to people with disabilities, families, state departments, community providers, individual support coordinators, and community case managers providing case management services to adults with mental retardation and autism.

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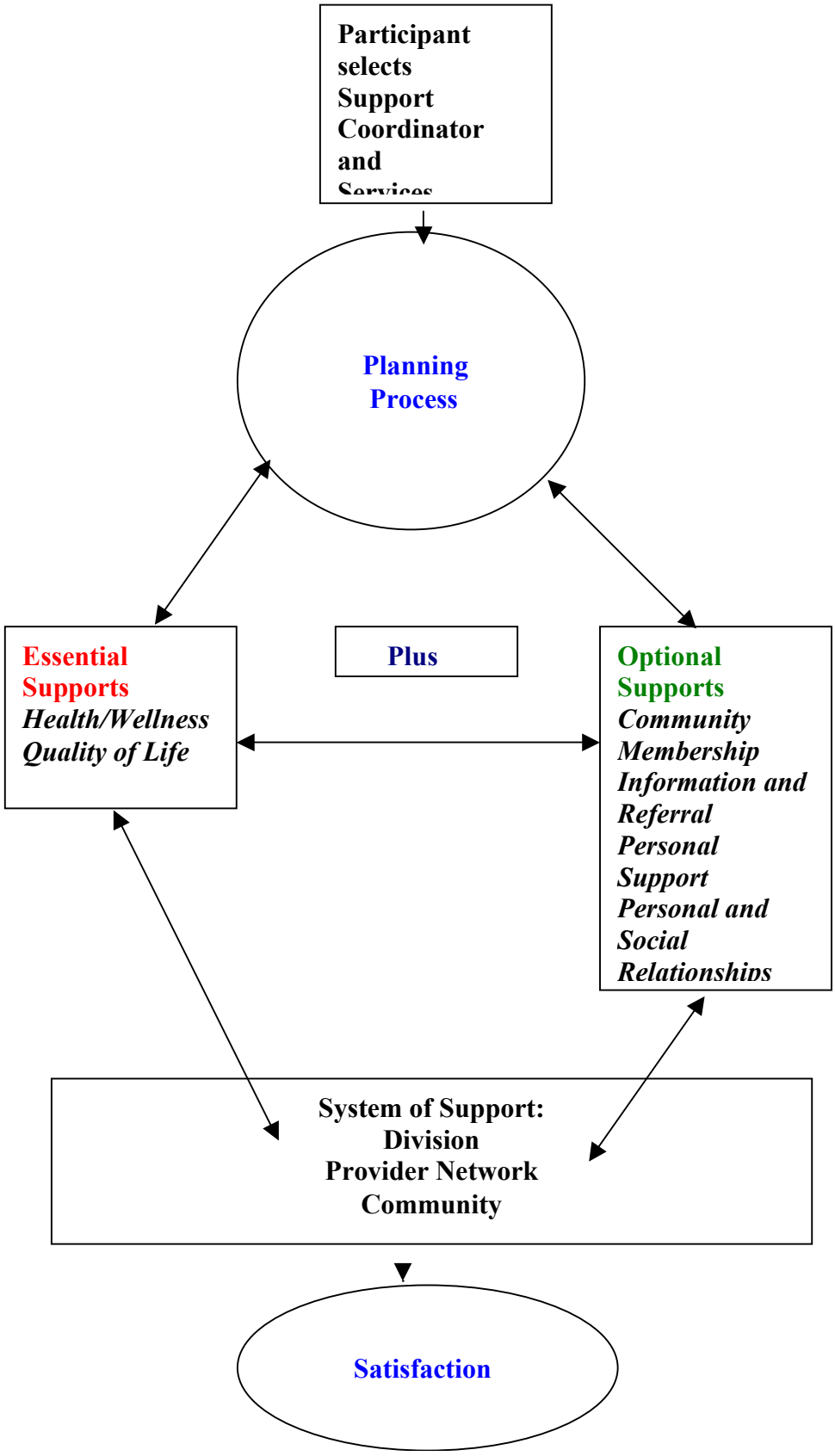
Participant selects Support Coordinator and
Planning Process
Essential Supports
Health/Wellness
Quality of Life
Plus
Optional Supports
Community Membership
Information and Referral
Personal Support
Personal and Social Relationships
System of Support:
Division
Provider Network
Community
Satisfaction

II. Definitions

1. **"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish; sexual abuse or exploitation; or the willful deprivation of essential needs.**
2. **"Advocate" means an employee of the Office of Advocacy.**
3. **"Caretaker" means an individual who has or who assumes responsibility for the care of an adult.**
4. **Client" or "Consumer" means a person applying for or receiving mental retardation supports and /or services, or the person for whom those services are requested.**

5. **"Commissioner" means the Commissioner of the Department of Behavioral and Developmental Services.**
6. **"Community Case Manager" - means a person hired through a contracted provider agency with the responsibility for coordinating a persons planning process and services.**
7. **"Consultant" means an individual, agency, form, or organization that is independent of the Department of Mental Health, Mental Retardation and Substance Abuse Services**
8. **"Consumer" or "Client" means a person applying for or receiving mental retardation supports and /or services, or the person for whom those services are requested.**
9. **"Crisis" means any incident, behavior, activity, or pattern of activity, which could lead to the loss of a person's residence, program, or employment. A crisis may also be an incident that results in undue mental or emotional stress or trauma that may endager the welfare of the person.**
10. **"Deaf" means a condition in which a person's sense of hearing is non functional for the purpose of spoken communication; with or without hearing aids. Communication must occur through visual and/or tactile means.**
11. **"Department" means the Department Behavioral and Developmental Services (BDS).**
12. **"Danger" means a situation or condition of abuse, neglect exploitation or serious harm.**
13. **"Emergency" means an unforeseen event or condition requiring prompt action**
14. **"Emergency Services" mean those services necessary to avoid serious harm.**
15. **"Guardianship" means a legal relationship by virtue of which a guardian is given authority to make decisions regarding the person of a ward. The guardian of an individual who is mentally retarded or incapacitated adult may be appointed by will or by a court pursuant to 18-A MRSA 5-301 et seq, and 5-601 et seq.**
16. **"Individual Support Coordinator" (ISC) means the regional staff of Mental Retardation Services with the responsibility for coordinating a persons planning process and services.**
17. **"MRS" means Mental Retardation Services of the Department.**
18. **"Personal Planning" means a person centered planning process (PCP) where the needs and desires of the person are articulated and identified and an action plan is created to address those needs and desires.**
19. **"Primary Support Staff" means the individuals who have or who assume responsibility for the care of an adult.**
20. **"Public Guardian" means Mental Retardation Services or the Department of Human Services when appointed as such by a court pursuant to 18-A MRSA 5-601 et seq.**

III. Eligibility for Service

Case management is a reimbursable service for individuals age 18 or older who have mental retardation, and who live at home with a specified adult relative. Case management is reimbursable by MaineCare when provided by individual support coordinators employed by the Department of Behavioral and Developmental Services (BDS), or by staff of provider agencies under contract with BDS.

Community Case Management: Defining the Service

Using a person-centered planning process, the community case manager will work with the participant, and others identified by the participant, in the development of an individualized support plan which will reflect the participant's personal vision for a desired life. The case manager will assist the participant, and others, in identifying support strategies that can be implemented to guide the participant to reach (attain) self-identified goals and wishes. Support strategies must incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. The community case manager will work closely with the participant to assure his/her ongoing satisfaction with the process by making sure that the activities selected always reflect the supports and services desired, and needed, by the participant. In addition, the case manager will analyze the outcomes of the supports and services implemented, and will monitor available resources to support the participant's plan. Strategies and implementation plans must be comprehensive and address the following: health and safety of the participant; housing and employment; social networking; scheduling and documentation of appointments and meetings, including on-going person-centered planning; utilization of natural and community supports; and the quality of the various supports and services utilized by the participant.

Community Case Management Service Delivery Model.

This model identifies various components associated with support coordination. It identifies services as ***Essential*** and ***Optional.*** This model allows persons who are eligible for services to fashion support coordination in a manner that maximizes the participant's control by creating a flexible service menu therefore fashioning support coordination in a manner that focuses effort towards the individual's personal vision for his/her life.

Essential services are not intended to be intrusive. Rather the services are tailored to focus on the health and wellness of all participants and to offer assistance, guidance and support around skill development designed to help keep the participants safe from harm and exploitation.

Optional services are designed to promote the participant's priorities and thus be a reflection of the participant's future planning process.

Essential Services:

Health and Wellness:

Health and Wellness involves activities designed to promote, support and maintain the participant's overall health. When necessary and indicated *, activities may include:

- Coordination and arrangement of medical and dental appointments and treatments
- Coordination and arrangement of mental health treatment and services
- Coordination and arrangement for nutritional/fitness support
- Coordination and arrangement for any therapies needed (i.e.PT, OT, speech, etc)
- Assistance in acquiring and usage of any needed medical equipment
- Assistance with the management of chronic illnesses and condition
- Assistance with grief counseling as needed

* Necessary and indicated refers to activities identified and documented as such in the person-centered planning process, and with which the participant will require assistance in order to achieve. Ex. A person with diabetes who is not able to independently coordinate and arrange for needed medical care, and requires additional supports to maintain health.

Quality of Life:

Quality of Life is a category of service that balances freedom of choice and individual lifestyle, with personal responsibility and system accountability. The focus should always be on promoting the participant's personal competencies that would result in safety and freedom from abuse, neglect and exploitation. Such activities could include:

- Assist, coordinate and secure information on services and options that are available so that decisions are informed choices

- Offer assistance and coordination obtaining legal resources such as partial or full guardianship
- Assist in the coordination and/or mediation of problem resolutions that may arise with housing, employment, community membership and day support services
- Coordinate services, or engage directly with the participant, to avoid or resolve a crisis, or any other challenging personal situation.
- Assist, coordinate or complete any required reporting obligation

Optional Services:

Community Membership:

Community Membership is a group of services designed to assist the participant in understanding and accessing the neighborhood and community in which one lives. In essence, the purpose of Community Membership services is to locate, and connect the participant, to sources of personal support in their community that enhance the participant's vision for a desired life. Services may include:

- Assist, coordinate or introduce the participant to community groups, agencies and organizations that reflect the participant's personal interest and vision for a desired life (churches, Weight Watchers, hiking clubs as examples)
- Assist, coordinate or arrange opportunities for the participant to volunteer in activities that reflect the participant's personal interest
- Assist, coordinate or provide information and training on local resources and how to use those resources
- Assist, coordinate or locate support groups that may reflect the participant's interest
- Assist, coordinate or arrange for cooperatives or similar self-help activities

Information and Referral:

Information and Referral is a group of services designed to ensure that the participant has access to information. When necessary and indicated*Services may include:

- Obtaining information and assisting, coordinating or making referrals to federal programs such as SSI and housing programs
- Obtaining information, and assisting the participant in obtaining benefits from the state to which they are entitled, i.e. MaineCare (formerly Medicaid), Medicare, prescription drug programs, welfare, vocational supports, educational supports as examples
- Obtaining information, and assisting or coordinating in the making of referrals for medical and or mental health services

- Obtaining information, and assisting or coordinating in the making of referrals for membership in local support or self-help groups
- Obtaining information, and assisting in the participant's ability to understand the support system including their rights, responsibilities, grievance options and the decision-making process

Personal Support and Coordination

Personal Support and Coordination is a group of services designed to offer assistance and supports to promote the participant's articulation of a personal vision for a desired life in the community. When necessary and indicated*, services in this category may include:

- Assist, coordinate or facilitate the participant's future planning process
- Assist in coordination of opportunities for the participant to attend preferred community activities;
- Assist in the coordination of opportunities for the participant to attend those activities with people who are friends and allies rather than agency staff;
- Assist in the coordination of options that offer a greater variety of activities in which the participant can become engaged;
- Assist in the coordination of opportunities for the participant to engage in more activities with friends and allies and without paid staff
- Assist in the coordination of the expanding the network of the participant's social relations to include more individuals who are not agency staff.

Some of the last things seem repetitive, but I am not sure what you mean.

Personal and Social Relationships

Personal and Social Relations is a group of services designed to connect the participant to sources of personal support in the community. When necessary and indicated*Services and supports may include:

- Assist in, coordinate or arrange the provision of instruction, guidance, modeling and mentoring
- Assist in the coordination, or facilitate referrals for adult education, memberships in community groups, agencies or organizations and or volunteering with community projects
- Assist in the coordination or provision of physical and or other support that may be necessary to participant in community events

- Assist in the coordination and arranging of one to one relationship building, with a decided preference for natural supports from family, friends, neighbors and allies,
- Assist in the coordination and arranging of modeling, mentoring and support from people associated with other generic community and civic organizations

Assist, coordinate, facilitate, desired outcomes such as connections to sources of support through families, friends, allies or people associated with community or civic organization

CASE MANAGEMENT STANDARDS

Mental Retardation Services adheres to a set of Case Management Standards that are very closely based upon the National Association of Social Workers (NASW) Standards approved by the NASW Board of Directors in June of 1992. The interested reader is referred to www.naswdc.org/practice/standards/casemgmt.htm. Following is a presentation of the 10 standards, in some cases modified slightly in order to be maximally applicable to the consumers whom we serve.

Note- The bullets following the standard and descriptions if necessary are policies found in the Case Management Policy Section that reflect theses standards.

Standard 1. The Case manager shall meet the standard set forth in the job description of a community case manager for Mental Retardation Services.

Standard 2. The Case manager shall use his or her professional skills and competence to serve the consumer, whose interests are of primary concern.

Case Managers have two sorts of ethical obligations. First: to resolve all scheduling and procedural conflicts by giving preeminent consideration to the concerns of consumers and their families. While the convenience of a Case Manager is a legitimate concern, during the workday it is secondary to the convenience of the consumer. As professionals, Case Managers are obligated to hold both themselves and their agency to the highest possible ethical standards.

- Consumer/Individual Support Coordinator Relationship
- Client rights
- The Rights of Maine Citizens With Mental Retardation

Standard 3. The Case Manager shall ensure that consumers are involved in all phases of case management practice to the greatest extent possible.

The primary vehicle for assuring that consumers achieve this autonomy is the Person Centered Plan. However, some consumers elect not to have a Plan, and the Case Manager has the same obligations in these cases.

- Personal Planning Process/Protocol PCP
- Mission Statement

Standard 4. The Case Manager shall ensure the consumer's right to privacy and ensure appropriate confidentiality when information about the consumer is released to others.

Case Managers are reminded that even in cases where a particular consumer appears to be unconcerned or uninterested in issues of privacy and confidentiality, Case Managers are still obligated to adhere to a high standard.

- Release of information

Standard 5. The Case Manager shall intervene at the consumer level to provide and/or coordinate the delivery of direct services to consumers and their families.

Mental Retardation Services in the State of Maine are highly integrated with community resources. For this reason, the particular shape of case management services will differ greatly from one consumer to the next. In some instances, the Case Manager may be virtually the only liaison for the consumer and their family, while in other cases a consumer may be receiving a wide variety of services from an established agency or provider. Accordingly the Case Manager may be operating as a direct Social Worker in one case, as a service coordinator in another, and as a quality assurance monitor in another. In all likelihood, a given Case Manager will have the whole spectrum of types of cases, and will need to develop skills in a variety of areas. Standard 5 speaks primarily to the direct service category, while the following standards address coordination and quality assurance. In addition to possessing good interpersonal and communication skills, a Case Manager needs to develop, through education or experience, an understanding of interpersonal and family dynamics, as well as a good background in the nature and needs of various disabilities. This is particularly true since many of the consumers whom we serve have secondary diagnoses related to mental health, substance abuse, or physical disabilities. Further, some consumers have children, with whom they may need assistance. Others may be involved in difficult family situations. This manual cannot comprehensively identify all the areas in which a Case Manager may be called upon to act, but it is nonetheless an expectation of the Department that Case Managers will strive to expand their skill base across this entire spectrum of topics.

- Eligibility
- Referral and Intake
- Personal Planning Process
- Access to services and supports
- Mental Retardation Policies

Standard 6. The Case Manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services.

Case Managers are expected to become progressively more knowledgeable about resources available to consumers throughout their communities**,** to assist the

participant in understanding and accessing the neighborhood and community in which they live. In essence the primary responsibility is to locate and connect people to sources of personal support in the community that enhance the participant's vision for a desired life. It is expected that Case Managers will take every opportunity to share any information that they gather with all of their colleagues, in order to strengthen the service coordination and delivery system for the system as a whole.

Standard 7. The Case Manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities.

- Family Support Program
- Financial Procedures, community resources, department resources, entitlements

Standard 8. The Case Manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability.

- Quality Improvement Activities
- Grievance and Appeal
- MR/DD Quality Improvement Plan

Standard 9. The Case Manager shall carry a reasonable caseload that allows him to effectively plan, provide, and evaluate case management tasks related to consumer and system interventions.

Standard 10. The Case Manager shall treat colleagues with courtesy and respect, and strive to enhance interprofessional, intraprofessional, and interagency cooperation on behalf of the consumer.

VI. Access and Time Frames

Case management services must be accessed through Mental Retardation Services through the Intake and Referral Policy as follows:

REFERRAL AND INTAKE

I. Introduction

Intake is a process by which a person with mental retardation/autism/or pervasive developmental disorder and Mental Retardation Services establish a formal relationship.

People referred to the Department are considered to be in intake status until eligibility is determined. Eligibility is defined in the MR services policy entitled Eligibility for Mental Retardation Services. (34B MRSA Section 5465) People are eligible for MR services for adults at the age of 18.

Foreign language and/or sign language interpreters must be utilized whenever there is a communication barrier to comply with Federal and State Laws concerning equal access to service**.**

II. REFERRAL

A. The referral/intake process begins when a request for MR services is made by a person with mental retardation/autism or PDD or by any person or agency acting on behalf of the person who is not currently or has not in the past

received services from MR services. The consumer and/or guardian must consent to the referral unless it is an Adult Protective Referral. This consent can be given by the person or guarding over the phone. Persons acting on behalf of the individual must provide a sign release prior to information being accepted by BDS.

B. Each regional office has established a procedure whereby a referral can be accepted at any time so that a person making a referral is not required to re-contact the regional office. The staff person accepting the initial referral is responsible for completing the referral information used by a regional office. While completing this form, the staff person should attempt to determine the applicant's circumstances and need for services, how the applicant may be contacted, the possible need for emergency intervention, as well as the identifying information indicated on the form. The staff person accepting the referral should be sufficiently aware of MR Services to answer general questions regarding services.

III. INTAKE

A. The referral information is forwarded to the regional supervisor who assigns responsibility for completion of the intake process to the appropriate staff person. This person will be referred to as the intake worker. Eligibility may be determined at any point during the referral/intake process once enough information is available to ascertain the eligibility of the individual.

B. The intake worker assigned will proceed promptly with all prescribed intake activities. The initial contact will take place within 10 working days of the initial referral. For Adult Protective referrals, action should be taken as soon as possible. Specific actions to be taken in this situation are outlined in the cooperative agreement between MR Services and Adult Protective. Copies of this are available in each regional office. The intake worker shall contact the applicant, or other informant, in order to obtain Permission for Service. The Permission for Service form establishes the basis for an ongoing relationship between the applicant and MR Services. The form permits MR Services to act on behalf of the person with mental retardation. The competent adult with mental retardation/ autism/PDD should sign the permission for himself or herself. The term "competence" used here implies the ability of the client to understand the nature of the services to be provided, and the appropriateness of such services for himself or herself. In some cases, incompetence may have already been determined by the court and therefore, the person will have a court appointed guardian. The working assumption is that if legal incompetence has not been established by the court the applicant is, therefore, competent. Competence may later be clarified by court action. A competent person with mental retardation or his legal guardian may decline MR Services. The date of the sign permission shall be considered the date that the intake process has begun. At this time the intake worker will determine whether a visit is necessary at this time or at a later date. If the individual is already

receiving case management from Children's Services as an example it may not be necessary to do a visit if all relevant information is available for intake.

C. If available information from the source of referral indicates that pre-arrangement of the visit is not advisable, this fact should be noted and documented. The goals of a visit are: the functional assessment of the applicant, the compilation of historical and biographical information regarding the applicant, and the completion of various forms related to the intake. The selection of the site of the visit should be in an environment familiar and comfortable for the applicant in order to gain the greatest insight regarding the applicant's behavior, needs, and abilities; the need for emergency intervention; or the availability of an informant. Based upon what is known about the applicant and his or her circumstances, consideration of the above factors may indicate that one setting is more expedient, or that one setting may yield the most relevant information.

D. It is not intended that the intake worker will make a diagnosis of mental retardation/autism or pervasive developmental disabilities (PDD). The primary purpose of the intake is to gather information in order to determine eligibility. In addition, information is collected to assist in preliminary service planning. To these ends, the intake worker shall:

1. Collect pertinent demographic data
2. Determine the nature and type of services already provided to the person
3. Identify service needs
4. Collect information regarding developmental history and current living arrangements
5. Determine what information will be needed to establish eligibility
6. Provide the referral source an opportunity to receive an explanation of MR services
7. Provide services or referral for singular immediate needs particularly regarding health and safety.
8. Begin to gather information for a service plan.

IV. INTAKE DOCUMENTATION

A. The intake worker is responsible for the completion of various required documents.

The forms to be completed include:

1. The information sheet on EIS
2. The Permission for Service;
3. The Release of Information, (to);
4. The Release of Information, (from), as required; and

5. Intake assessment.

In addition, the intake worker will arrange for a psychological evaluation unless current copies can be obtained from another source.

B. Information Sheet

The information sheet (EIS) is completed at the intake. The form serves as a source of information regarding the applicant. Upon acceptance of the applicant for services, the form will become the face sheet for the case record.

C. Release of Information (to)

This form gives permission for MR Services to release specific information to a designated person or agency. A separate release is required each time information is disclosed. The original signed release stays in the case record.

Only records or information which are generated by MR services and which will not be harmful to the consumer may be authorized for release. All such information should be stamped "Privileged and Confidential Information, Not to be Used Against Client's Best Interest".

E. Release of Information (from)

This form authorizes the release of information generated by the primary source to MR Services. The release is specific to the agency noted in the release and the information requested. A separate release should be completed for each agency from which information will be requested. It should be understood that the release form authorizes the one-time release of information from the primary source, and that the authorization is specific to the information specified on the form. When requesting additional information from a particular agency, a new Release of Information form should be completed. The intake worker should insure that the "to" section on the release is filled in prior to asking an applicant or legal guardian to sign. The original signed form will be sent to the agency from which information is requested.

F. Intake Assessment

This document provides the structure to the assessment phase of the intake process. It provides a basis for a psychosocial evaluation of the prospective client.

V. Establishing the Need for Evaluation

A. **An updated psychological evaluation may be requested at the discretion of the Regional Supervisor in order to determine a diagnosis of mental**

retardation/autism. This may be particularly necessary in the referral of children transitioning to adult services considering the potential for growth and achievement. A licensed Ph.D., psychologist or a licensed psychological examiner, must conduct the evaluation. Additional professional assessments may include physical examination, psychiatric evaluation, physical therapy evaluation, occupational therapy evaluation, speech and hearing evaluation, etc. Foreign language and/or sign language interpreters must be utilized whenever there is a communication barrier to comply with Federal and State Laws concerning equal access to service**.**

C. The intake worker, through observation and interview, may determine areas where further evaluation may be useful. Certain professional evaluations may be indicated solely on the basis of the timeliness of the available information. Other needs for evaluation may become obvious during the intake process. Evaluations requested that are not directly related to determination of eligibility should not delay a decision being made within the accepted time frame.

D. The intake process should be completed within 60 days. The end date for completion is date of a letter of eligibility. If the process can not be completed within 60 days a letter will be provided to the applicant explaining that eligibility has not been determined and providing specific information as to why with a projected completion date. The office of Advocacy will be notified. If at the projected date the eligibility cannot be determined the applicant will be contacted again in writing explaining the reason for a decision not being made with another projected date. The office of Advocacy will again be notified.

VI. Disposition of a Referral

A. Once the intake worker has completed the intake assessment and other necessary forms, and has obtained a current psychological evaluation, the intake worker will meet with the regional supervisor to discuss all of the relevant information obtained by the intake process.

B. Denial of Services

1. If the Regional Supervisor determines that the applicant does not meet the established criteria, (See Eligibility for Mental Retardation Services in Case Management Manual) the person will be denied mental retardation services. To the greatest extent possible, the intake worker and the Regional Supervisor will attempt to suggest to the applicant or to the referral source, alternative services.

2. The applicant and/or the individual acting on behalf of the applicant shall be informed of the denial in writing and when necessary via other appropriate means, and given notice of their right to appeal that decision and of the availability of the Office of Advocacy to provide

assistance. (See Eligibility for Mental Retardation Services in Case Management Manual)

C. Acceptance for Services

1. If the Regional Supervisor determines that the applicant meets the eligibility criteria, he or she will be accepted for MR Services. The Regional Supervisor and intake worker will determine the case management status based on the criteria in the case status procedures. (See case management status procedures active, inactive, closed in case management manual.) The person will be informed in writing of their eligibility and will be provided with:
    a. A statement of rights, information about the grievance process and the availability of the Office of Advocacy;
    b. Information about the case status to which the person has been assigned;
    c. If assigned to Active status, the name of the ISC and contact information. For all other statuses, the name and title of a person to contact.
2. A psychosocial will be written by the intake worker for transfer to case management or to the person covering the inactive case status.

The intake worker for transfer to case management or inactive case status will write an initial service plan. (If an applicant had not met with a representative of the department until acceptance, a meeting will occur at this time to review needs and develop a service plan.)

Referral to Private Case Management:

When eligibility determination is made and case management services is identified, as a need the service needs to be provided within 90 days. The Regional Supervisor will make a determination as to whether the person meets the criteria for community case management. If this is the case the following steps will be taken:

A. Inform the person in writing of their right to access case management services through a community provider. The option of state case managmenet services will be identified at the time of eligibility and will be contingent on ratios within the regional office of origin. (See

B. Provide the person/guardian with information regarding agencies providing this service in their community.

C. Arrange for interviews by the person/guardian of case management agencies.

VII. PERSONAL PLANNING POLICY

A. Community Support Coordinators will plan with individuals for the coordination and delivery of supportive and other services through the development of a personal plan. The type of plan, participants and agenda at the planning meeting will be selected by the individual and/or their guardian.

B. The personal planning process will be:

1. Understandable and in plain language or if the individual is deaf, non-verbal, signing, or speaks another language; the process will include qualified interpreters.

2. Focused on the person's choice

3. Reflective of and supportive of the person's goals and aspirations

4. Developed at the direction of the consumer and include people the consumer chooses

5. Flexible enough to change as new opportunities arise

6. Reviewed according to a specified schedule and by a person designated for monitoring

7. Inclusive of the needs and desires of the person without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed

8. Inclusive of a provision for assuring each person's satisfaction with the quality of the plan and the supports he/she receives

C. The plan will focus on the supports identified by the individual.

D. The plan will be written and approved by the consumer/guardian and the action plan will be entered in EIS within 30days of the meeting date.

E. The plan may be facilitated by the consumer, a case manager, other agencies providing major services to the individual, family members or other persons chosen by the consumer.

F. The planning team will always develop a service plan or action plan which outlines the agreements reached by the team. The planning team will follow the needs/desires policy in regards to time frames for identified needs and interim plans for unmet needs.

VIII. Personnel

A. Qualifications

A. A case manager must have a minimum of a bachelor's degree from an accredited four (4) year institution of higher learning with a specialization in psychology, behavioral health, social work, special education, counseling, rehabilitation, nursing, or a closely related field.

B. Supervision

B. A supervisor of case management must have a baccalaureate degree plus a minimum of four years experience in the mental retardation field. The supervisor must also have experience supervising staff providing services to persons with mental retardation, knowledge of the public education system in Maine, and training in flexible funding and family-focused service provision. Supervisors are responsible for supervising individual support coordinators or case managers, developing and reviewing service plans, and assuring the provision of quality case management services.

The agency must have policies and procedures regarding the provisions of supervision of Case Managers. The policies and procedures must address the need for a minimum of _____ a month of supervision with access

IX. Confidentiality

(I will forward this section from Children's Services to Nancy Christianson to for her review to assure compliance with HIPPA)

X. Discontinuation of Community Case Management

Discontinuation of Community Case Management may occur for several reasons including:

1. **The needs of the individual no longer meet the criteria of active case** management. (Refer to active case management in procedure manual).

2. The needs of the individual exceed the roles and responsibilities of a community case manager. (Examples include needing waiver level of services, needing representative payee, needing public guardianship.)

3. The person moves from the area or the state.

4. The person chooses to leave the organization that they receive case management services from.

1. In the event that case management considered to be no longer needed this would be identified in the persons plan and would be referred to a regional Supervisor for review for inactive status and the following procedures would occur.

Inactive case management status assigned to people who have been found eligible for Mental Retardation Services, receive services from the department, (ex. Day hob, respite, family support) but do not require case management services at the present time because there is a reliable history of natural supports providing the case management functions. A Mental Retardation Case Management Supervisor makes the determination.

The following describe some situations in which inactive case management may be appropriate:

- No legal involvement or if there is a legal issue the person has an attorney representing them.
- Not a class member

- A class member who has refused case management services. If annual follow-up is refused case will be placed in closed status.
- Not under public guardianship
- Assistance in managing financial issues is not needed or assistance is available.
- Routine health care that is arranged without the assistance of a case manager.
- Program/work/housing are stable
- Healthy relationships with family, friends, natural supports
- No planning needed or receives from another source such as day program or housing
- Representative Payee – someone outside the Department provides Service.

Monitoring of Inactive Case Management Status

Each Regional Office will ensure the monitoring of people in inactive case management status. This may be done through a contracted service or by assigning a staff person other than an Individual Support Coordinator with an active caseload. Monitoring will include at least an annual face-to-face contact with each consumer unless the consumer specifically requests not to be contacted. All such request will be documented. All contacts will be documented in the file. In addition a letter will be sent annually asking the if they are satisfied with the degree and scope of services being provided as well as reviewing their rights, review of the grievance and appeal process, and access to the Office of Advocacy. This letter will identify the regional contact person.
The Regional Office will ensure that:

- There are timely responses to requests made by individuals in this status
- Assistance in connecting individuals with services in their community is provided when needed.
- There is adequate monitoring of the level of need and recommendations made to the Case Work Supervisor regarding the need for a change is case management status. (See case status change procedure.)

2. If the needs of the person exceed what the community case manager can provide those needs have to be identified in the person centered planning process. A review of the case would occur between the community case managers supervisor and the liaison for Mental Retardation Services as well as a Regional Supervisor for Mental Retardation Services. A determination will be made within 30 days of the request for review as to whether case management should be transferred to State case management.

3. If the person is moving to another area of the state resulting in the need to change the community case manager/agency it is the responsibility of the case manager to facilitate that transfer by identifying potential providers of the service in the area and arranging for interviews by the person/family. It is also the responsibility for the case manager to inform the local BDS office as well as the office in the region the person is moving to.

If the person is moving out of state it is the responsibility of the case manager to assist in connecting to potential service providers in the state the person is moving to if requested by the person/guardian as well as providing notice to the BDS office as soon as the case manager is informed. When case management ends, presumably when the person leaves the state, the case should be closed. (See Closed Status for Case Management)

4. If a person request a change in case manager or agency it is the responsibility of the person and their family to give a 30-day notice to the case manager. It is then the responsibility of the case manager to assist the person /family to identify a new service.